STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155106	A. BUILDING 00 B. WING	06/17/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERWALK VILLAGE	295 WESTFIELD ROAD NOBLESVILLE, IN46060

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	This visit was for a Recertification and State Licensure survey. Survey dates: June 13, 14, 15, 16, and 17, 2011 Facility number: 000044 Provider number: 155106 AIM number: 100274940 Survey team: Janet Stanton, R.N.--Team Coordinator Rita Mullen, R.N. Michelle Hosteter, R.N. Heather Lay, R.N. Courtney Mujic, R.N. (6/14, 15, 16, 17) Census bed type: SNF/NF--147 Total--147 Census payor type: Medicare--18 Medicaid--117 Other--12 Total--147 Sample: 24 These deficiencies reflect State findings cited in accordance with 410 IAC 16.2.	F0000	The Creation and submission of this Plan of Correction does not constitute and admission by this Provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulationThis Provider respectfully requests that the 2567 Plan of Correction be considered the letter of credible allegation and requests a post survey review on or after 07/10/11	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	Quality review completed 6/22/11 Cathy Emswiller RN			
F0241 SS=D	The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. Based on observation and record review, the facility failed to ensure that 3 of 3 residents' lower body clothing was positioned in a dignified and appropriate manner, in that the residents' slacks/pants were twisted around to the side of their bodies and/or not pulled up causing bunching in between the legs. This deficiency effected 3 residents in a sample of 24 residents reviewed. [Residents #1, #8, and #13] Findings include: 1. On 6/14/11 at 11:30 A.M., Resident #8 was observed sitting on a chair scale in the hallway of the Memory Care II [Alzheimer's/secured] unit. The chair scale was placed near the Dining Room/Activity area. Four other residents passed Resident #8 on their way to the Dining Room for the lunch meal. Other unit staff, including a housekeeper, were also in the immediate area. Two C.N.A.s were assisting Resident #8 as she was	F0241	F241 - Dignity It is the consistent practice of this Provider to promote care for residents in a manner and in an environment that maintains or enhances each residents dignity and respect in full recognition of his or her individuality.I. Resident #8 - Upon the surveyors sharing this information with the facility, the resident was checked and was appropriately wearing clothes in a neat and respectful mannerResident #1 - Upon the surveyors sharing this information with the facility, the resident was checked and was appropriately wearing clothes in a neat and respectful mannerResident #13 - Upon the surveyors sharing this information with the facility, the resident was checked and was appropriately wearing clothes in a neat and respectful manner.II. All residents have the potential to be affected by the alleged practice. Facility Residents were reviewed and assessed to be dressed and / or properly clothed in a neat, respectful and dignified	07/10/2011

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	being weighed. The resident was observed sitting on the chair scale with a gait belt around her upper waist area. The left pant leg of her slacks was pulled up to her mid-thigh area, exposing her lower leg and knee. The front mid-line seam of the resident's slacks [from the waist to the crotch] was observed to be twisted around to the residents' lower body, left side of her body. The resident's shirt was observed to be pulled up under the gait belt, so that the belt was laying against her skin. The elastic waist band of the resident's slacks was positioned mid-way between the resident's waist and her buttocks, exposing her mid-lower back area. Before assisting her to stand, one of the C.N.A.s did pull the resident's shirt down, and positioning it under the gait belt. As the C.N.A.s lifted the resident from the chair scale and pivoted her into her wheelchair, the resident's slacks were observe to be hanging down in the back, with the front mid-line seam from the waist band to the crotch twisted around to the left side. The resident was then lowered into her		manner. Daily rounds will occur by a dept manager and/or designee to monitor and ensure resident dignity.III.Staff were re-inserviced on July 5th by the Staff Development Coordinator promoting care for residents in a manner and in an environment that maintains and enhances each residents dignity.Failure to follow this Providers policies, standards of practice and or expectations will result in further re-education, disciplinary action and/or lead up to termination.IV.A Dignity CQI audit will occur weekly x4; if threshold is met then monthly x3 to ensure the environment and employees consistently ensure the proper dignity for residents. The governing CQI committee will review the data; if threshold is not obtained, an action plan will be developed.The Director of nursing and/or designee is responsible for ongoing monitoring and compliance.	

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	wheelchair, and taken to the Dining Room. The clinical record for Resident #8 was reviewed on 6/14/11 at 10:10 A.M. Diagnoses included, but were not limited to, dementia, depression, and anxiety. The annual M.D.S. [Minimum Data Set] assessment, dated 11/3/10, indicated the resident's B.I.M.S. [Brief Interview for Mental Status] score was a "1"--"severe impairment" in cognitive status. A quarterly assessment B.I.M.S. score, dated 5/18/11, indicated the interview was unable to be completed, with the resident refusing to answer or providing only nonsensical answers. The quarterly assessment also indicated the resident required the physical assistance of 1 staff person for all daily care, including toileting and dressing. 2. On 6/15/11 at 2:25 P.M., Resident #1 was observed sitting in his wheelchair at a table in the Dining/Activity room on the Memory Care II [Alzheimer's/secure] unit. The resident stood up from his wheelchair several times, setting off the pressure-pad alarm. At 2:30 P.M., L.P.N. #2 approached and asked the resident if he would like to lay down in bed. The resident nodded "yes."			

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	The L.P.N. then walked with the resident to his room. The resident's sweat pants were observed to have the elastic waist band positioned at the left side of the resident's body. The front seam twisted around from the crotch to the waist band, so that the pant legs inseam was at the resident's left thigh area. The clinical record for Resident #1 was reviewed on 6/17/11 at 11:40 A.M. Diagnoses included, but were not limited to, dementia with behaviors, dysphagia, bilateral carotid stenosis, and history of increased confusion requiring hospitalization. An initial M.D.S. [Minimum Data Set] assessment, dated 5/20/11, indicated the resident's B.I.M.S. [Brief Interview for Mental Status] score was a "3"--"severe impairment" in cognitive status. The assessment also indicated the resident required the physical assistance of 1 staff person for all daily care, including dressing and toileting. 3. On 6/17/11 at 10:45 A.M., Resident #13 was observed sitting in his wheelchair in the Dining/Activity room on the Memory Care II [Alzheimer's/secure] unit. He was positioned near the center of the			

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room, with other residents and staff in the area.

The elastic waist band of the resident's sweat pants was observed to be twisted around to the left side of his body, with the front seam twisted to the left from the crotch to the waist band.

The resident continued to sit in the Dining/Activity room until 11:30 A.M., when he was assisted to a table for the lunch meal.

The clinical record for Resident #13 was reviewed on 6/15/11 at 2:20 P.M. Diagnoses included, but were not limited to, dementia with behaviors, chronic venous insufficiency, chronic kidney disease, insulin-dependent diabetes, neuropathy, lower extremity edema, and obesity.

An initial M.D.S. [Minimum Data Set] assessment, dated 2/17/11, indicated the resident's B.I.M.S. [Brief Interview for Mental Status] score was a "12"--"moderate impairment" for cognitive status. A quarterly assessment, dated 5/6/11, indicated the resident's B.I.M.S. score had declined to a "6"--"severe impairment" for cognitive status. The assessments also indicated the resident required the physical assistance of 1-2

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	staff for all daily care, including dressing and toileting. 3.1-3(t)			
F0280 SS=D	The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. Based on record review and interview, the facility failed to develop a coordinated care plan identifying facility and hospice responsibilities for resident for hospice care services for 2 of 2 residents reviewed in a sample of 24 residents. [Residents #111 and #92] Findings include: 1. During the initial tour with L.P.N. #1	F0280	F280 Right to Participate Planning Care - It is the consistent practice of this Provider to develop a coordinated care plan identifying facility and hospice responsibilities for residents on hospice.I.Resident #111 - this residents care plan was reviewed and revised as needed to further develop a coordinated care plan identifying facility and hospice responsibilities.Resident #92 - This residents care plan was	07/10/2011

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	on 6/13/11 at 10:50 A.M., she identified that resident #111 was receiving hospice services due to liver cancer. Record review for Resident #111 was done on 6/17/11 at 10:10 A.M.. Diagnoses included, but were not limited to, cirrhosis of the liver, liver cancer, and dementia. The record identified that the resident was admitted to hospice 5/26/10. The facility care plan dated 9/21/10 with a goal date of 8/30/11, the care plan identified " ...Needs Hospice care due to terminal condition of : Liver cirrhosis...Hospice care program ...." Interventions included: "... Observe for complaints of pain or discomfort and do interventions as ordered, encourage visitors, observe for abnormal weight loss, appetite, skin breakdown, notifying physician as needed, encourage activity and socialization daily, and listen to the resident and discuss concerns as needed." There was no mention of what type of services the hospice agency would provide and when they would provide them. There was no identification of when the C.N.A.s would provide ADL [activities of daily living] care, such as bathing or hygiene; or how these services were coordinated with hospice aides. There was no mention of pain management and how that would be		reviewed and revised as needed to further develop a coordinated care plan identifying facility and hospice responsibilities.II.All residents on hospice services have the potential to be affected by the alleged practice.This Provider reviewed and revised if necessary all resident care plans that were receiving hospice services. Coordinated plan of care was further developed identifying facility and hospice responsibilities for residents on hospice with the Hospice staffIII.Upon admitting a patient with hospice, a coordinated plan of care will be developed with hospice staff identifying facility and hospice services. The IDT team have been re-educated on coordinated care plans by Seasons Hospice nursing Director - Lezlie Heagy on Friday June 24th. Nursing staff have been re-educated on the Care plan process along with the required coordinated involvement of all team members on July 5 by the Staff Development Coordinator.IV. A Care Plan CQI will be used weekly x4; if threshold is met then monthly x3 to ensure care plans of hospice residents are coordinated. The governing CQI committee will review the data; if threshold is not obtained, an action plan will be developed. The Director of Nursing and/or designee will be responsible for ongoing monitoring and compliance.	

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	handled with the hospice agency. The hospice care plan identified "... FACILITY and/or INPATIENT management...." The care plan identified areas such as comfort and safety, quality of life through maintaining skin integrity, hygiene, mobility, prevention/containment of infection, safe use of equipment, medication, supplies, seizure management. The care plan also identified that the resident would receive hospice aide services which included bathing and hygiene assistance as well as pain management. In an interview with L.P.N. #1 6/17/11 at 11 A.M. she identified this was the only care plan the facility had for Resident #111 for hospice services. In requesting all hospice care plans from Assistant DON, she further identified that these were the only care plans at this time for these services. 2. During the initial tour with L.P.N. #1 on 6/13/11 at 10:50 A.M., she indicated Resident #92 had been a victim of a gunshot wound, had a recent decline, and was now receiving hospice services. The resident was admitted to hospice services on 4/14/11, due to cardiac concerns.			

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	Record review for Resident #92 was done on 6/17/11 at 9:27 A.M. Diagnoses included, but were not limited to, congestive heart failure, subarachnoid hemorrhage [bleeding in the brain], quadriplegic [paralyzed from the neck down], and depression. The care plan dated 5/13/11 indicated "... Resident is receiving hospice services related to diagnosis of: end stg [stage] cardiac [heart].... Hospice services per hospice plan of care, notify MD and hospice of unrelieved pain...." There was no documentation of how they were planning to coordinate services between hospice and facility pertaining to care provided to resident by each entity in the areas of comfort, safety, pain management or ADL care. The hospice care plan dated 4/14/11 indicated "... FACILITY and/or INPATIENT management...." The care plan identified that facility staff will understand and deliver care needed to maintain patient comfort/safety and understand desired palliative [pain management] approach.. In an interview with the assistant director of nursing on 6/17/11 at 9:45 A.M. she identified that she provided copies of all of the current hospice care plans for the			

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	resident for the current time. 3.1-35(c)(2)(C)			
F0282 SS=D	The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on record review and interview, the facility failed to follow the Care Plan for a Resident on fluid restrictions. This impacted 1 of 1 Residents reviewed on fluid restrictions in a sample of 24. (Resident #147) Findings include: The clinical record of Resident #147 was reviewed on 6/15/11 at 2:30 P.M. Diagnoses included, but were not limited to, depression, chronic renal failure, congestive heart failure and high blood pressure. A Care plan, dated 5/3/11, indicated Resident #147 had a problem with "...Recurrent abdominal distention related to ascites, recent paracentesis, expected wgt (weight) fluctuation r/t refusal to comply with renal diet, dialysis, fluid restriction. Approaches included, but were	F0282	F282 Services by Qualified Persons / per Care Plan - It is this Providers consistent practice to follow the residents Plan of Care.I.Resident #147 - The care plan was reviewed and revised as appropriate for the resident. This resident is now on dialysis so the gerth measurement that was a nursing measure was removed as an intervention on June 24.II.All residents have the potential to be affected by the alleged practice. Resident care plans were reviewed, revised and updated as needed. Treatment sheets were audited for items needing to be re-evaluated by the physician.III.The staff were reinserviced on updating careplans. All treatment orders will be reviewed at least monthly for continued need, any items will be discussed with the physician as needed.IV.A MAR/TAR CQI will be be completed weekly x4; if threshold is met then quarterly to ensure MAR/TAR are followed and properly documented as complete. The governing CQI	07/10/2011

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	not limited to, "Observe for excessive fluid retention, abdominal distention, edema, increased discomfort, shortness of breath and report. Measure girth every day, this intervention was dated 5/1/11 and hand written on the Care Plan. A review of the Treatment Record for the month of May 2011 indicated the Resident's abdominal girth was measured 14 of 31 times. A review of the Treatment Record for the month of June 2011, indicated the Resident's abdominal girth, as of 6/16/11, was measured 1 of 16 times. During an interview with LPN #4, on 6/16/11 at 10:15 A.M., she indicate the abdominal girth measurement was not being done. 3.1-35(g)(2)		committee will review the data; if threshold is not obtained, action plan will be developed. The Director of Nursing and/or Designee will be responsible for ongoing monitoring and compliance.	

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F0431 SS=D	The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on record review and interview, the facility failed to ensure all discontinued Schedule II/narcotic medications were disposed of appropriately, for 1 of 3 residents reviewed who were discharged from the facility; in a sample of 24 residents. [Resident #151]	F0431	F431 Drug Records, Labels/Store Drugs & Biologicals - It is the consistent practice of this Provider to ensure discontinued Schedule II/Narcartic medications are disposed of appropriately.I. Resident #151 - This resident does not reside at this facilityII.All residents with d/c'd Schedule	07/10/2011

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	Findings include: The closed clinical record for Resident #151 was reviewed on 6/15/11 at 9:30 A.M. The resident expired in the facility on 3/31/11 at 12:40 P.M. The March, 2011 physician order recap [recapitulation] sheet listed medications which included, but was not limited to, the Schedule II medications of Morphine Sulfate, Oxycodone, and Ativan [Lorazepam]. A. The Controlled Medication sign-out sheet indicated Lorazepam Intensol solution [2 milligrams per 1 milliliter] was to be given at 0.25 ml [milliliter] for 0.5 mg. [milligram] dose four times a day. An amount of 30 ml was initially dispensed from the pharmacy. On 3/31/11 at 9:00 A.M. a dose was given, leaving an amount of 24.25 ml. The sign-out sheet had a line drawn across the remainder of the form under the last dose given. A hand-written note indicated "RHC [respirations have ceased] 3/31/11," with some additional writing that was illegible. A box at the upper right corner of the form, under "Doses Transferred to Disposal Record," a "Quantity" of 24.25 on "Date" of 3/31/11" was initialed by a nurse on the "Nurse's Signature" line.		II/Narcotic medications have the potential to be affected by the alleged practice.All residents discharged in the last ninety days drug disposition records were audited, any issues identified were addressed by disciplinary action or re-educationIII.Nursing staff have been re-inserviced by the Staff Development Coordinator on Tue July 5th on the proper disposal of medication and required documentation.All narcotic medications that are discontinued will be destroyed for two licensed nurses. The disposition of the medication will be documented on the disposition record at the time of the medication destruction including method of destruction.IV.A Medication Disposal CQI to audit narcotic disposition will be used weekly x4; if threshold is met then monthly x3 to esnure medications are properly disposed. The governing CQI committee will review data; if threshold is not met, an action plan will be developed. The Director of Nursing and/or Designee will be responsible for monitoring and ongoing compliance.	

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	155106	A. BUILDING 00 B. WING	06/17/2011

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A "Disposal Record" form, listing the liquid Lorazepam and disposition of the medication with a witness, was not found. There was no other information on the sign-out sheet to indicate if the medication was flushed/destroyed or returned to the pharmacy.

In an interview during the daily conference on 6/16/11 at 3:25 P.M., the Director of Nursing indicated the additional writing on the sign-out sheet was the signatures of 2 nurses.

B. A second Controlled Medication sign-out sheet for Lorazepam Intensol, to be given at 0.25 ml. for 0.5 mg. every 4 hours as needed for anxiety. An amount of 30 ml was delivered by the pharmacy on 3/29/11, and no doses had been given of the P.R.N. [as needed] medication. The form had the same documentation as the first sign-out sheet, with "RHC 3/31/11," and "30 ml" transferred to a disposal record. A "Disposal Record" form, listing the liquid Lorazepam and disposition of the medication with a witness, was not found. There was no other information on the sign-out sheet to indicate if the medication was flushed/destroyed or returned to the pharmacy.

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	C. A third Controlled Medication sign-out sheet indicated Morphine Sulfate solution [20 mg per 1 ml solution] was to be given at 0.5 ml for a 10 mg. dose four times a day. The pharmacy delivered 30 ml of solution on 3/25/11. An entry on 3/26/11 indicated no doses had been given, leaving 30 ml. There were no other entries, and no doses of the medication were documented as given. The sign-out sheet had a line drawn across the remainder of the form under the last dose given. A hand-written note indicated "RHC [respirations have ceased] 3/31/11," with some additional writing that was illegible. A box at the upper right corner of the form, under "Doses Transferred to Disposal Record," a "Quantity" of 30 ml. on "Date" of 3/31/11" was initialed by a nurse on the "Nurse's Signature" line. A "Disposal Record" form, listing the liquid Morphine Sulfate and disposition of the medication with a witness, was not found. There was no other information on the sign-out sheet to indicate if the medication was flushed/destroyed or returned to the pharmacy. In an interview during the daily conference on 6/16/11 at 3:25 P.M., the			

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	Director of Nursing indicated the additional writing on the sign-out sheet was the signatures of 2 nurses. In the interview on 6/16/11, the Director of Nursing indicated she had contacted the nurses whose signatures were on the Controlled Medication sign-out sheets and had them write a note about the disposition of the medications. Each nurse indicated in their statement that 18.0 ml. of Oxycodone solution and 162 Morphine Sulfate tablets had been flushed down the toilet. 3.1-25(s)			
F0514 SS=D	The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. Based on record review and interview, the facility failed to accurately record the amount of fluid intake for a Resident on fluid restriction. This impacted 1 of 1	F0514	F514 Records Complete/Accurate/Accessible - It is the consistent practice of this Provider to maintain clinical records on each resident that are	07/10/2011

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	Residents reviewed on fluid restrictions in a sample of 24. (Resident #147) Findings include: The clinical record of Resident #147 was reviewed on 6/15/11 at 2:30 P.M. Diagnoses included, but were not limited to, depression, chronic renal failure, ascites, congestive heart failure and high blood pressure. A Care plan, dated 5/3/11, indicated Resident #147 had a problem with "...Recurrent abdominal distention related to ascites, recent paracentesis, expected wgt (weight) fluctuation r/t refusal to comply with renal diet, dialysis, fluid restriction. Approaches included, but were not limited to, "Observe for excessive fluid retention, abdominal distention, edema, increased discomfort, shortness of breath and report. Measure girth every day. A quarterly Minimum Data Set assessment, dated 3/16/11, indicated Resident #147 was cognitive intact and able to make decisions. A Physician order, dated 6/6/11, indicated "Send res (Resident)...for paracentesis (ascites)...."		complete and accurate.I. Resident #147 - Residents records were reviewed and audited and as of the compliance date of 7/10/11, the record is complete and accurately recorded.II.All residents with fluid restrictions have the potential to be affected with the alleged practice.Residents with fluid restrictions will be monitored and accurately documented as ordered as of 7/10/11.III.Nursing staff were re-inserviced by the Staff Development Coordinator on July 5 regarding this Providers policy, procedure and expectaton on maintaining clinical records on each resident that are complete and accurate. . Staff failure to follow this Providers policies, procedures and expectations will be re-educated, disciplined and/or lead up to termination.IV.A MAR/TAR CQI audit will occur weekly x4; if threshold is met then monthly x3 to ensure the residents MAR are accurately maintained and properly recorded. The governing CQI committee will review the data; if threshold is not met, an action plan will be developed. The Director of Nursing and/or Designee is responsible for ongoing monitoring and compliance.	

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A Physician order, dated 6/7/11, indicated "1440 cc (cubic centimeters) fluid restriction.

A Physician order, dated 6/9/11, indicated "Clarification of fld restriction 1440 cc/day. Dietary to provide 720 cc. B-240 cc, L-240 cc, D-240 cc. Nursing to provide 720 cc. 10-6 120 cc, 6-2 240, 2-10 240 cc...."

A review of the Medication Administration Record (MAR), dated June 2011, recorded the amount of fluids Resident #147 was receiving form Nursing, it was illegible.

A meal intake record, dated for the month of June 2011, indicated the amount of Resident #147's fluid intake was over the daily amount ordered by the Physician. There were no intake totals.

A Care Plan, dated 6/14/11, indicated Resident #147 was noncompliant with fluid restrictions.

During an interview with the Dietary Manager, on 6/16/11 at 1:30 P.M. she indicated dietary is sending the amount of fluids the Physician ordered but the Resident asks for more.

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	During an interview with L.P.N. #1 , on 6/16/11 at 3:00 P.M., she indicated the fluids Nursing gives are written on the MAR. There was no daily Intake and Output record. 3.1-50(a)(1)			
F0516 SS=E	A facility may not release information that is resident-identifiable to the public. The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. The facility must safeguard clinical record information against loss, destruction, or unauthorized use. Based on observation and interview, the facility failed to secure, store, and protect resident clinical record information against loss, destruction, and unauthorized use, in 1 of 1 facility medical records office. Findings include: During the environmental inspection tour on 6/16/11 at 9:45 A.M., with the Maintenance Supervisor and Housekeeping/Laundry Supervisor in	F0516	F516 Safeguard Clinical Records - It is the consistent practice of this Provider to secure, store, and protect resident clinical record information against loss, destruction, and unauthorized use.I.No residents were cited in this alleged definciency.II.All residents have the potential to be affected by the alleged practice. Resident record thinned files and related overflow items were properly filed and where appropriate sent out to Iron Mountain which is off-site medical records facility this Provider uses	07/10/2011

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	attendance, the following was observed: When the Medical Records office was approached during the inspection, the door was observed to be unlocked and partially cracked open. There was no one in attendance in the room. The office was located in a main hallway across from the Station I Nurses Station. In an interview at that time, the Maintenance Supervisor indicated the door was supposed to be locked whenever no one was in the room, and that he did not have a key to that room. The office had multiple, and too numerous to count, metal file cabinets side by side around the perimeter of the room. A row of metal file cabinets filled the center of the room. Loose resident clinical record information paperwork was observed to be piled on top of each of the file cabinets, 1 to 2 feet high. In an interview on 6/16/11 at 11:00 A.M., the Medical Records staff person indicated some of the paperwork was information thinned from multiple resident current active records, and some was scheduled to be transferred to an off-site medical records storage facility.		for record safe keeping.III.The Medical Records staff person was disciplined and re-educated on the proper filing and safe keeping of resident medical records. Nursing staff were re-educated on July 5th by the Staff Development Coordinator on the related to this Providers practice to secure, store, and protect resident record information against loss, destruction, and unauthorized use. Failure of staff to follow this Providers Policy, procedures and expectations will result in further re-education, discipline and/or lead to termination.IV.The Maintenance director will monitor the door, lock and automatic closure weekly thru the preventative maintenance program to ensure the medical records door is securely closed and locked. The Executive Directo and/or Director of Nursing will monitor the medical records storge weekly to ensure resident records are properly filed or securely placed in weather proof tubs to ensure the records are secure, stored and protected against loss, destruction and unauthorized use.	

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	3.1-50(d)			